Health Financial Systems | SOUTHERN INDIANA REHAB HOSPITAL | In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S Parts I-III | Date/Time Prepared: 5/29/2013 9:04 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2013 Time: 9:04 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SOUTHERN INDIANA REHAB HOSPITAL (153037) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 5/29/2013 Time: 9:04 pm
B54SqCG9ZSjJfigxDm.ROfFE:hoBs0
SAQRZOcr3O6qSar2K2fTfOMaUbUXcF
IwVj0HlAGoORpdkO
PI: Date: 5/29/2013 Time: 9:04 pm
IwIEmZvdFOwl4Ol28O.B8ZZ1uPGVG0
YpKvDOs..GxFpR.Lud.pZJrybhkD1T
8PqdOofgQwOp4ivp

(Signed) Officer or Administrator of Provider(s)

Title: President

Date: 5/30/13

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	15,722	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	15,722	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 153037	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 9:04 pm

PART I - COST REPORT STATUS

Provider use only

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2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
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   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SOUTHERN INDIANA REHAB HOSPITAL (153037) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	15,722	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	15,722	0	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA — Provider CCN: 153037 — Period: From 01/01/2012 To 12/31/2012 — Worksheet S-2 Part I — Date/Time Prepared: 5/29/2013 9:02 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3104 BLACKISTON BOULEVARD	PO Box:			1.00
2.00	City: NEW ALBANY	State: IN	Zip Code: 47150	County: FLOYD	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SOUTHERN INDIANA REHAB HOSPITAL	153037	31140	5	03/01/2002	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SOUTHERN INDIANA REHAB HOSPITAL	155765	31140		08/03/2007	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	5		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	163	54	0	0	68	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 9:02 pm

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N	39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2013 9:02 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	76.00

		1.00		
	Long Term Care Hospital PPS			
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
	TEFRA Providers			
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA — Provider CCN: 153037 — Period: From 01/01/2012 To 12/31/2012 — Worksheet S-2 Part I — Date/Time Prepared: 5/29/2013 9:02 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	45,006	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	188006	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: JHSMH INC	Contractor's Name: CGS	Contractor's Number: 15101	141.00
142.00	Street: 539 SOUTH FOURTH STREET	PO Box:		142.00
143.00	City: LOUISVILLE	State: KY	Zip Code: 40202	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 9:02 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/01/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 9:02 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			Y	06/30/2012	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		BKP LLP	BKP LLP		41.00
42.00	Enter the employer/company name of the cost report preparer.		BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		502-581-0435	LVCOSTREPORTS@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2013 9:02 pm

		Part B Date 4.00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	05/01/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD LLP		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2013 9:02 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	34	12,444	0.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		34	12,444	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		34	12,444	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	26	9,516		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	99.00				0	25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		60				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

	Component	I/P Days / O/P Visits / Trips Title XVIII	Title XIX	Total All Patients	Full Time Equivalents Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	5,752	217	8,266			1.00
2.00	HMO	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	558	68				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,752	217	8,266			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	5,752	217	8,266	0.00	164.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	5,294	0	7,941	0.00	27.49	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2013 9:02 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
27.00	Total (sum of lines 14-26)				0.00	191.81	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	478	23	669	1.00
2.00	HMO			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	478	23	669	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0.00					25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-7 | Date/Time Prepared: 5/29/2013 9:02 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	14	0	14	3.00
4.00		RUL	179	0	179	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	11	0	11	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	3	0	3	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	411	0	411	12.00
13.00		RUB	1,000	0	1,000	13.00
14.00		RUA	3,313	0	3,313	14.00
15.00		RVC	9	0	9	15.00
16.00		RVB	31	0	31	16.00
17.00		RVA	158	0	158	17.00
18.00		RHC	7	0	7	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	7	0	7	20.00
21.00		RMC	10	0	10	21.00
22.00		RMB	14	0	14	22.00
23.00		RMA	90	0	90	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	3	0	3	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	6	0	6	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	2	0	2	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	14	0	14	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	1	0	1	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	9	0	9	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	1	0	1	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-7 | Date/Time Prepared: 5/29/2013 9:02 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		5,294	0	5,294	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	31140	31140	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,591,330			207.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	553,712	553,712	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	356,454	356,454	2.00
4.00	00400	EMPLOYEE BENEFITS	48,870	106,926	155,796	1,933,309	2,089,105	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	391,803	3,004,727	3,396,530	-1,094,055	2,302,475	5.00
6.00	00600	MAINTENANCE & REPAIRS	203,831	451,939	655,770	-45,138	610,632	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,928	4,449	25,377	-4,449	20,928	8.00
9.00	00900	HOUSEKEEPING	195,047	74,082	269,129	-41,076	228,053	9.00
10.00	01000	DIETARY	279,466	456,887	736,353	-59,668	676,685	10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,569	83,042	179,611	-24,708	154,903	16.00
17.00	01700	SOCIAL SERVICE	565,334	149,532	714,866	-122,962	591,904	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	139,490	56,791	196,281	-30,416	165,865	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,979,968	787,672	2,767,640	-400,069	2,367,571	30.00
44.00	04400	SKILLED NURSING FACILITY	1,019,289	314,251	1,333,540	-219,281	1,114,259	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	-3,564	-3,564	0	-3,564	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,407	86,407	0	86,407	54.00
60.00	06000	LABORATORY	0	159,722	159,722	0	159,722	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	33,806	362,017	395,823	-7,164	388,659	65.00
66.00	06600	PHYSICAL THERAPY	2,301,327	662,200	2,963,527	-754,121	2,209,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,075,016	267,358	1,342,374	-59,241	1,283,133	67.00
68.00	06800	SPEECH PATHOLOGY	639,685	162,413	802,098	-55,847	746,251	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,138	1,138	0	1,138	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,277	1,277	0	1,277	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	213,558	213,558	0	213,558	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	737,294	737,294	0	737,294	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	255,620	201,777	457,397	-55,106	402,291	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	604	604	0	604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,246,049	8,342,499	17,588,548	-129,826	17,458,722	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	129,826	129,826	194.00
200.00		TOTAL (SUM OF LINES 118-199)	9,246,049	8,342,499	17,588,548	0	17,588,548	200.00

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	553,712		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	184,522	540,976		2.00
4.00	00400	EMPLOYEE BENEFITS	-8,361	2,080,744		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	992,940	3,295,415		5.00
6.00	00600	MAINTENANCE & REPAIRS	-2,721	607,911		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,928		8.00
9.00	00900	HOUSEKEEPING	0	228,053		9.00
10.00	01000	DIETARY	-64,475	612,210		10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,250	141,653		16.00
17.00	01700	SOCIAL SERVICE	0	591,904		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	165,865		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-132,032	2,235,539		30.00
44.00	04400	SKILLED NURSING FACILITY	0	1,114,259		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,980	416		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,121	79,286		54.00
60.00	06000	LABORATORY	7,834	167,556		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-23,905	364,754		65.00
66.00	06600	PHYSICAL THERAPY	-108,816	2,100,590		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,350	1,281,783		67.00
68.00	06800	SPEECH PATHOLOGY	-50,358	695,893		68.00
69.00	06900	ELECTROCARDIOLOGY	-1,121	17		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-156	1,121		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-8,534	205,024		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-22,481	714,813		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-134,322	267,969		76.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	-52	552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0	0	99.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	610,221	18,068,943	118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	129,826	194.00
200.00		TOTAL (SUM OF LINES 118-199)	610,221	18,198,769	200.00

RECLASSIFICATIONS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-6 | Date/Time Prepared: 5/29/2013 9:02 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	1,933,309		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	1,933,309		
	B - RENT/LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	101,002		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	101,002		
	C - INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	39,050		1.00
	TOTALS		0	39,050		
	D - PUBLIC RELATIONS					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	129,826		1.00
	TOTALS		0	129,826		
	E - THERAPY REHAB ADMIN					
1.00	OCCUPATIONAL THERAPY	67.00	161,407	8,009		1.00
2.00	SPEECH PATHOLOGY	68.00	75,515	3,747		2.00
	TOTALS		236,922	11,756		
	F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	553,712		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	216,402		2.00
	TOTALS		0	770,114		
	G - DAY TREATMENT					
1.00	PHYSICAL THERAPY	66.00	225	40		1.00
2.00	OCCUPATIONAL THERAPY	67.00	123	22		2.00
3.00	SPEECH PATHOLOGY	68.00	58	10		3.00
	TOTALS		406	72		
500.00	Grand Total: Increases		237,328	2,985,129		500.00

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	82,693	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	43,179	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	4,449	0	3.00
4.00	HOUSEKEEPING	9.00	0	40,892	0	4.00
5.00	DIETARY	10.00	0	58,060	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	20,396	0	6.00
7.00	SOCIAL SERVICE	17.00	0	119,484	0	7.00
8.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	28,775	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	395,490	0	9.00
10.00	SKILLED NURSING FACILITY	44.00	0	215,531	0	10.00
11.00	RESPIRATORY THERAPY	65.00	0	7,164	0	11.00
12.00	PHYSICAL THERAPY	66.00	0	500,144	0	12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	228,802	0	13.00
14.00	SPEECH PATHOLOGY	68.00	0	135,177	0	14.00
15.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	53,073	0	15.00
	TOTALS		0	1,933,309		
	B - RENT/LEASE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	72,372	10	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	1,959	0	2.00
3.00	HOUSEKEEPING	9.00	0	184	0	3.00
4.00	DIETARY	10.00	0	1,608	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,312	0	5.00
6.00	SOCIAL SERVICE	17.00	0	3,478	0	6.00
7.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	1,641	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	4,579	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	0	3,750	0	9.00
10.00	PHYSICAL THERAPY	66.00	0	5,564	0	10.00
11.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	1,555	0	11.00
	TOTALS		0	101,002		
	C - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,050	12	1.00
	TOTALS		0	39,050		
	D - PUBLIC RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	129,826	0	1.00
	TOTALS		0	129,826		
	E - THERAPY REHAB ADMIN					
1.00	PHYSICAL THERAPY	66.00	236,922	11,756	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		236,922	11,756		
	F - DEPRECIATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	770,114	9	1.00
2.00		0.00	0	0	9	2.00
	TOTALS		0	770,114		
	G - DAY TREATMENT					
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	406	72	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		406	72		
500.00	Grand Total: Decreases		237,328	2,985,129		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part I Date/Time Prepared: 5/29/2013 9:02 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	425,000	0	0	0	0	1.00
2.00	Land Improvements	128,046	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,795,612	16,775	0	16,775	0	3.00
4.00	Building Improvements	382,927	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,725,791	80,250	0	80,250	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,457,376	97,025	0	97,025	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,457,376	97,025	0	97,025	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	425,000	0	1.00
2.00	Land Improvements	128,046	0	2.00
3.00	Buildings and Fixtures	14,812,387	0	3.00
4.00	Building Improvements	382,927	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,806,041	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,554,401	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	20,554,401	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2013 9:02 pm

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2013 9:02 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	15,748,360	0	15,748,360	0.766179	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,806,041	0	4,806,041	0.233821	0	2.00
3.00	Total (sum of lines 1-2)	20,554,401	0	20,554,401	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	553,712	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	400,924	101,002	2.00
3.00	Total (sum of lines 1-2)	0	0	0	954,636	101,002	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	553,712	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	39,050	0	0	540,976	2.00
3.00	Total (sum of lines 1-2)	0	39,050	0	0	1,094,688	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/29/2013 9:02 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-1,859	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-153,347			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,289,839			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-8,418	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,627	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DIETARY - RENTAL REV	B	-12,432	DIETARY	10.00	0	33.00
33.01	RENTAL INCOME	B	-11,859	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MISCELLANEOUS REVENUE	B	-1,659	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	INTEREST INCOME	B	-2,303	ADMINISTRATIVE & GENERAL	5.00	0	33.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/29/2013 9:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.04	MISC INCOME - ST	B	-25,138	SPEECH PATHOLOGY	68.00	0	33.04
33.05	MISC INCOME - PSYCH	B	-1,210	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	33.05
33.06	MISC INCOME - PT	B	-108,816	PHYSICAL THERAPY	66.00	0	33.06
33.07	MISC INCOME - OT	B	-1,350	OCCUPATIONAL THERAPY	67.00	0	33.07
33.08	LOBBY % OF DUES	A	-2,178	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TELEPHONE SERVICES	A	-30,812	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	SCOTT COUNTY ST	A	-16,722	SPEECH PATHOLOGY	68.00	0	33.10
33.11	SCOTT COUNTY ST - BENEFITS	A	-3,118	EMPLOYEE BENEFITS	4.00	0	33.11
33.12	TRANSPORTATION	A	-111,797	ADULTS & PEDIATRICS	30.00	0	33.12
33.13	TRANSPORTATION - BENEFITS	A	-5,243	EMPLOYEE BENEFITS	4.00	0	33.13
33.14	MALPRACTICE INSURANCE	A	-45,006	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	CIVIC ACTIVITIES/COMMUNITY BENEFIT	A	-84,308	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	DIETARY INSTRUCTIONS	B	-48,416	DIETARY	10.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		610,221				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2013 9:02 pm

Line No.		Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00		2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL-CLARK ANCILLARIES	11,114	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HIM-CLARK ANCILLARIES	28,194	33,026	2.00
3.00	50.00	OPERATING ROOM	RECOVERY ROOM-CLARK ANCILLARIES	103	73	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY-CLARK ANCILLARIES	1,412	1,359	4.00
4.01	60.00	LABORATORY	LAB ADMINISTRATION-CLARK ANCILLARIES	150,243	139,642	4.01
4.02	73.00	DRUGS CHARGED TO PATIENTS	IV THERAPY-CLARK ANCILLARIES	38,282	21,801	4.02
4.03	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY-CLARK ANCILLARIE	302,358	326,263	4.03
4.04	69.00	ELECTROCARDIOLOGY	EKG-CLARK ANCILLARIES	17	17	4.04
4.05	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	MEDICAL SUPPLIES-CLARK ANCILLARIES	124,243	132,777	4.05
4.06	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY-CLARK ANCILLARIES	61,669	73,045	4.06
4.07	91.00	EMERGENCY	EMERGENCY ROOM-CLARK ANCILLARIES	493	485	4.07
4.08	6.00	MAINTENANCE & REPAIRS	PLANT ENGINEERING-FLOYD ANCILLARIES	0	2,721	4.08
4.09	50.00	OPERATING ROOM	OPERATING ROOM-FLOYD ANCILLARIES	312	-3,638	4.09
4.10	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY-FLOYD ANCILLARIES	73,434	80,608	4.10
4.11	60.00	LABORATORY	LAB-FLOYD ANCILLARIES	17,164	19,931	4.11
4.12	68.00	SPEECH PATHOLOGY	SPEECH THERAPY-FLOYD ANCILLARIES	0	8,498	4.12
4.13	69.00	ELECTROCARDIOLOGY	EKG-FLOYD ANCILLARIES	0	1,121	4.13
4.14	70.00	ELECTROENCEPHALOGRAPHY	EEG-FLOYD ANCILLARIES	1,121	1,277	4.14
4.15	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY-FLOYD ANCILLARIES	546,310	573,896	4.15
4.16	91.00	EMERGENCY	EMERGENCY ROOM-FLOYD ANCILLARIES	59	119	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION-MANAGEMENT FEE JEWISH	1,771,806	609,996	4.17
4.18	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED COSTS - JEWISH	184,522	0	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,312,856	2,023,017	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	JEWISH HOSPITAL	33.34	6.00
7.00	B		0.00	CLARK MEMORIAL	33.33	7.00
8.00	B		0.00	FLOYD MEMORIAL	33.33	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2013 9:02 pm

			Related Organization(s) and/or Home Office	
Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2013 9:02 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	11,114	0	1.00
2.00	-4,832	0	2.00
3.00	30	0	3.00
4.00	53	0	4.00
4.01	10,601	0	4.01
4.02	16,481	0	4.02
4.03	-23,905	0	4.03
4.04	0	0	4.04
4.05	-8,534	0	4.05
4.06	-11,376	0	4.06
4.07	8	0	4.07
4.08	-2,721	0	4.08
4.09	3,950	0	4.09
4.10	-7,174	0	4.10
4.11	-2,767	0	4.11
4.12	-8,498	0	4.12
4.13	-1,121	0	4.13
4.14	-156	0	4.14
4.15	-27,586	0	4.15
4.16	-60	0	4.16
4.17	1,161,810	0	4.17
4.18	184,522	9	4.18
5.00	1,289,839		5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE	6.00
7.00	HOME OFFICE	7.00
8.00	HOME OFFICE	8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2013 9:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	20,235	20,235	0	138,700	0	1.00
2.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	133,112	133,112	0	138,700	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			153,347	153,347	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	20,235		1.00
2.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	133,112		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	153,347		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	553,712	553,712				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	540,976		540,976			2.00
4.00	00400	EMPLOYEE BENEFITS	2,080,744	0	0	2,080,744		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,295,415	185,136	180,877	88,640	3,750,068	5.00
6.00	00600	MAINTENANCE & REPAIRS	607,911	0	0	46,114	654,025	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,928	0	0	4,735	25,663	8.00
9.00	00900	HOUSEKEEPING	228,053	0	0	44,127	272,180	9.00
10.00	01000	DIETARY	612,210	36,099	35,269	63,226	746,804	10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	141,653	0	0	21,847	163,500	16.00
17.00	01700	SOCIAL SERVICE	591,904	0	0	127,899	719,803	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	165,865	0	0	31,558	197,423	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,235,539	60,165	58,781	447,942	2,802,427	30.00
44.00	04400	SKILLED NURSING FACILITY	1,114,259	67,758	66,200	230,601	1,478,818	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	416	0	0	0	416	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,286	2,035	1,988	0	83,309	54.00
60.00	06000	LABORATORY	167,556	1,503	1,469	0	170,528	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	364,754	848	828	7,648	374,078	65.00
66.00	06600	PHYSICAL THERAPY	2,100,590	109,245	106,733	467,098	2,783,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,281,783	81,071	79,206	279,752	1,721,812	67.00
68.00	06800	SPEECH PATHOLOGY	695,893	5,172	5,053	161,818	867,936	68.00
69.00	06900	ELECTROCARDIOLOGY	17	0	0	0	17	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,121	0	0	0	1,121	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	205,024	0	0	0	205,024	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	714,813	1,388	1,356	0	717,557	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	267,969	3,292	3,216	57,739	332,216	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	552	0	0	0	552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,068,943	553,712	540,976	2,080,744	18,068,943	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	129,826	0	0	0	129,826	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	18,198,769	553,712	540,976	2,080,744	18,198,769	202.00

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,750,068					5.00
6.00	00600	MAINTENANCE & REPAIRS	169,748	823,773				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,661	0	32,324			8.00
9.00	00900	HOUSEKEEPING	70,643	0	970	343,793		9.00
10.00	01000	DIETARY	193,828	80,682	970	33,111	1,055,395	10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,435	0	0	1,696	0	16.00
17.00	01700	SOCIAL SERVICE	186,821	0	0	2,582	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	51,240	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	727,346	134,470	16,162	230,043	538,252	30.00
44.00	04400	SKILLED NURSING FACILITY	383,818	151,440	8,081	0	517,143	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,622	4,548	0	607	0	54.00
60.00	06000	LABORATORY	44,260	3,360	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	97,090	1,895	0	1,898	0	65.00
66.00	06600	PHYSICAL THERAPY	722,484	244,166	2,579	48,697	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	446,886	181,194	3,562	15,389	0	67.00
68.00	06800	SPEECH PATHOLOGY	225,268	11,560	0	3,645	0	68.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
69.00	06900	ELECTROCARDIOLOGY	4	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	291	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	53,213	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	186,238	3,101	0	456	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	86,225	7,357	0	5,669	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	143	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,716,372	823,773	32,324	343,793	1,055,395	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	33,696	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,750,068	823,773	32,324	343,793	1,055,395	202.00

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207,631					16.00
17.00	01700	SOCIAL SERVICE	0	909,206				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	248,663			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,897	463,719	126,825	5,145,141	0	30.00
44.00	04400	SKILLED NURSING FACILITY	101,734	445,487	121,838	3,208,359	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	524	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	110,086	0	54.00
60.00	06000	LABORATORY	0	0	0	218,148	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	474,961	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,801,592	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,368,843	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,108,409	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	21	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,412	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	258,237	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	907,352	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	431,467	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	695	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	207,631	909,206	248,663	18,035,247	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	163,522	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	207,631	909,206	248,663	18,198,769	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,145,141		30.00
44.00	04400	SKILLED NURSING FACILITY	3,208,359		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	524		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,086		54.00
60.00	06000	LABORATORY	218,148		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	474,961		65.00
66.00	06600	PHYSICAL THERAPY	3,801,592		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,368,843		67.00
68.00	06800	SPEECH PATHOLOGY	1,108,409		68.00
69.00	06900	ELECTROCARDIOLOGY	21		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,412		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,237		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	907,352		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	431,467		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
91.00	09100	EMERGENCY	695		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,035,247		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	163,522		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	18,198,769		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	185,136	180,877	366,013	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	36,099	35,269	71,368	0	10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	60,165	58,781	118,946	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	67,758	66,200	133,958	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,035	1,988	4,023	0	54.00
60.00	06000	LABORATORY	0	1,503	1,469	2,972	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	848	828	1,676	0	65.00
66.00	06600	PHYSICAL THERAPY	0	109,245	106,733	215,978	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	81,071	79,206	160,277	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,172	5,053	10,225	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,388	1,356	2,744	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,292	3,216	6,508	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	553,712	540,976	1,094,688	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	553,712	540,976	1,094,688	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	366,013					5.00
6.00	00600	MAINTENANCE & REPAIRS	16,568	16,568				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	650	0	650			8.00
9.00	00900	HOUSEKEEPING	6,895	0	20	6,915		9.00
10.00	01000	DIETARY	18,918	1,623	20	666	92,595	10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,142	0	0	34	0	16.00
17.00	01700	SOCIAL SERVICE	18,234	0	0	52	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	5,001	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,989	2,705	324	4,628	47,223	30.00
44.00	04400	SKILLED NURSING FACILITY	37,461	3,046	162	0	45,372	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,110	91	0	12	0	54.00
60.00	06000	LABORATORY	4,320	68	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	9,476	38	0	38	0	65.00
66.00	06600	PHYSICAL THERAPY	70,516	4,910	52	979	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,617	3,644	72	310	0	67.00
68.00	06800	SPEECH PATHOLOGY	21,987	233	0	73	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,194	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,177	62	0	9	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,416	148	0	114	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	14	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	362,724	16,568	650	6,915	92,595	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	3,289	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	366,013	16,568	650	6,915	92,595	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,176					16.00
17.00	01700	SOCIAL SERVICE	0	18,286				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	5,001			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,130	9,326	2,551	258,822	0	30.00
44.00	04400	SKILLED NURSING FACILITY	2,046	8,960	2,450	233,455	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	11	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,236	0	54.00
60.00	06000	LABORATORY	0	0	0	7,360	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,228	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	292,435	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	207,920	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	32,518	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	28	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,194	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,992	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	15,186	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	14	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,176	18,286	5,001	1,091,399	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	3,289	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,176	18,286	5,001	1,094,688	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	258,822		30.00
44.00	04400	SKILLED NURSING FACILITY	233,455		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	11		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,236		54.00
60.00	06000	LABORATORY	7,360		60.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	11,228		65.00
66.00	06600	PHYSICAL THERAPY	292,435		66.00
67.00	06700	OCCUPATIONAL THERAPY	207,920		67.00
68.00	06800	SPEECH PATHOLOGY	32,518		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,194		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,992		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	15,186		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		88.00
91.00	09100	EMERGENCY	14		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.00	09900	CMHC	0		99.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,091,399		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	3,289		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,094,688		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	71,831					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		71,831				2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	9,197,179			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,017	24,017	391,803	-3,750,068	14,448,701	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	203,831	0	654,025	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	20,928	0	25,663	8.00
9.00	00900	HOUSEKEEPING	0	0	195,047	0	272,180	9.00
10.00	01000	DIETARY	4,683	4,683	279,466	0	746,804	10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	96,569	0	163,500	16.00
17.00	01700	SOCIAL SERVICE	0	0	565,334	0	719,803	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	139,490	0	197,423	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,805	7,805	1,979,968	0	2,802,427	30.00
44.00	04400	SKILLED NURSING FACILITY	8,790	8,790	1,019,289	0	1,478,818	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	416	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	264	264	0	0	83,309	54.00
60.00	06000	LABORATORY	195	195	0	0	170,528	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	110	110	33,806	0	374,078	65.00
66.00	06600	PHYSICAL THERAPY	14,172	14,172	2,064,630	0	2,783,666	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,517	10,517	1,236,546	0	1,721,812	67.00
68.00	06800	SPEECH PATHOLOGY	671	671	715,258	0	867,936	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	17	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	1,121	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	205,024	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	180	180	0	0	717,557	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	427	427	255,214	0	332,216	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,831	71,831	9,197,179	-3,750,068	14,318,875	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	129,826	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	553,712	540,976	2,080,744		3,750,068	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.708538	7.531233	0.226237		0.259544	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		366,013	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.025332	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	
			6.00	8.00	9.00	10.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	47,814					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	58,163				8.00
9.00	00900	HOUSEKEEPING	0	1,745	67,916			9.00
10.00	01000	DIETARY	4,683	1,745	6,541	48,998		10.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	335	0	16,207	16.00
17.00	01700	SOCIAL SERVICE	0	0	510	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,805	29,081	45,445	24,989	8,266	30.00
44.00	04400	SKILLED NURSING FACILITY	8,790	14,541	0	24,009	7,941	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	264	0	120	0	0	54.00
60.00	06000	LABORATORY	195	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	110	0	375	0	0	65.00
66.00	06600	PHYSICAL THERAPY	14,172	4,641	9,620	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,517	6,410	3,040	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	671	0	720	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	180	0	90	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	427	0	1,120	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	0	0	99.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,814	58,163	67,916	48,998	16,207	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	823,773	32,324	343,793	1,055,395	207,631	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.228699	0.555748	5.062033	21.539553	12.811193	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	16,568	650	6,915	92,595	4,176	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.346509	0.011175	0.101817	1.889771	0.257666	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY) (TOTAL PATIENT DAYS)		
			17.00	18.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	16,207			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	16,207		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	8,266	8,266		30.00
44.00	04400	SKILLED NURSING FACILITY	7,941	7,941		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	0		99.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,207	16,207		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	909,206	248,663		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.099587	15.342938		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,286	5,001		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.128278	0.308570		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/29/2013 9:02 pm

					Title XVIII	Hospital	PPS	
					Costs		Charges	
		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,145,141		5,145,141	0	5,145,141	12,089,379	30.00
44.00	04400	SKILLED NURSING FACILITY	3,208,359		3,208,359	0	3,208,359	2,591,330	44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	524		524	0	524	49,728	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,086		110,086	0	110,086	307,946	54.00
60.00	06000	LABORATORY	218,148		218,148	0	218,148	1,661,909	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	474,961	0	474,961	0	474,961	1,996,978	65.00
66.00	06600	PHYSICAL THERAPY	3,801,592	0	3,801,592	0	3,801,592	8,893,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,368,843	0	2,368,843	0	2,368,843	7,469,751	67.00
68.00	06800	SPEECH PATHOLOGY	1,108,409	0	1,108,409	0	1,108,409	2,478,748	68.00
69.00	06900	ELECTROCARDIOLOGY	21		21	0	21	8,434	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,412		1,412	0	1,412	524	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,237		258,237	0	258,237	966,012	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	907,352		907,352	0	907,352	3,987,591	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	431,467		431,467	0	431,467	240,190	76.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
91.00	09100	EMERGENCY	695		695	0	695	15,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	0	92.00
		OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0		0		0	0	99.00
200.00		Subtotal (see instructions)	18,035,247	0	18,035,247	0	18,035,247	42,757,323	200.00
201.00		Less Observation Beds	0		0		0		201.00
202.00		Total (see instructions)	18,035,247	0	18,035,247	0	18,035,247	42,757,323	202.00

			Charges					
		Cost Center Description	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			7.00	8.00	9.00	10.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		12,089,379				30.00
44.00	04400	SKILLED NURSING FACILITY		2,591,330				44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,728	0.010537	0.000000	0.010537	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,000	308,946	0.356328	0.000000	0.356328	54.00
60.00	06000	LABORATORY	37,781	1,699,690	0.128346	0.000000	0.128346	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	299,101	2,296,079	0.206857	0.000000	0.206857	65.00
66.00	06600	PHYSICAL THERAPY	8,386,344	17,279,666	0.220004	0.000000	0.220004	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,032,903	9,502,654	0.249282	0.000000	0.249282	67.00
68.00	06800	SPEECH PATHOLOGY	1,967,956	4,446,704	0.249265	0.000000	0.249265	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,434	0.002490	0.000000	0.002490	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	524	2.694656	0.000000	2.694656	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	966,012	0.267323	0.000000	0.267323	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,987,591	0.227544	0.000000	0.227544	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,483,215	1,723,405	0.250357	0.000000	0.250357	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0				88.00
91.00	09100	EMERGENCY	0	15,481	0.044894	0.000000	0.044894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0				99.00
200.00		Subtotal (see instructions)	14,208,300	56,965,623				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,208,300	56,965,623				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I Date/Time Prepared: 5/29/2013 9:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,145,141		5,145,141	0	0	12,089,379	30.00
44.00	04400	SKILLED NURSING FACILITY	3,208,359		3,208,359	0	0	2,591,330	44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	524		524	0	0	49,728	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,086		110,086	0	0	307,946	54.00
60.00	06000	LABORATORY	218,148		218,148	0	0	1,661,909	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	474,961	0	474,961	0	0	1,996,978	65.00
66.00	06600	PHYSICAL THERAPY	3,801,592	0	3,801,592	0	0	8,893,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,368,843	0	2,368,843	0	0	7,469,751	67.00
68.00	06800	SPEECH PATHOLOGY	1,108,409	0	1,108,409	0	0	2,478,748	68.00
69.00	06900	ELECTROCARDIOLOGY	21		21	0	0	8,434	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,412		1,412	0	0	524	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,237		258,237	0	0	966,012	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	907,352		907,352	0	0	3,987,591	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	431,467		431,467	0	0	240,190	76.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
91.00	09100	EMERGENCY	695		695	0	0	15,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	0	92.00
		OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0		0		0	0	99.00
200.00		Subtotal (see instructions)	18,035,247	0	18,035,247	0	0	42,757,323	200.00
201.00		Less Observation Beds	0		0		0		201.00
202.00		Total (see instructions)	18,035,247	0	18,035,247	0	0	42,757,323	202.00

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		12,089,379					30.00
44.00	04400	SKILLED NURSING FACILITY		2,591,330					44.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	49,728	0.010537	0.000000	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,000	308,946	0.356328	0.000000	0.000000		54.00
60.00	06000	LABORATORY	37,781	1,699,690	0.128346	0.000000	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	299,101	2,296,079	0.206857	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	8,386,344	17,279,666	0.220004	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,032,903	9,502,654	0.249282	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,967,956	4,446,704	0.249265	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,434	0.002490	0.000000	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	524	2.694656	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	966,012	0.267323	0.000000	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,987,591	0.227544	0.000000	0.000000		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,483,215	1,723,405	0.250357	0.000000	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0.000000		88.00
91.00	09100	EMERGENCY	0	15,481	0.044894	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0					99.00
200.00		Subtotal (see instructions)	14,208,300	56,965,623					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	14,208,300	56,965,623					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part I Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	258,822	0	258,822	8,266	31.31	30.00
44.00	SKILLED NURSING FACILITY	233,455		233,455	7,941	29.40	44.00
200.00	Total (lines 30-199)	492,277		492,277	16,207		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,752	180,095	30.00
44.00	SKILLED NURSING FACILITY	5,294	155,644	44.00
200.00	Total (lines 30-199)	11,046	335,739	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11	49,728	0.000221	15,339	3	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,236	308,946	0.020185	129,276	2,609	54.00
60.00	06000	LABORATORY	7,360	1,699,690	0.004330	750,403	3,249	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	11,228	2,296,079	0.004890	768,756	3,759	65.00
66.00	06600	PHYSICAL THERAPY	292,435	17,279,666	0.016924	3,244,668	54,913	66.00
67.00	06700	OCCUPATIONAL THERAPY	207,920	9,502,654	0.021880	2,954,780	64,651	67.00
68.00	06800	SPEECH PATHOLOGY	32,518	4,446,704	0.007313	1,343,115	9,822	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,434	0.000000	3,436	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28	524	0.053435	524	28	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,194	966,012	0.005377	377,408	2,029	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,992	3,987,591	0.005264	1,649,094	8,681	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	15,186	1,723,405	0.008812	24,335	214	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	14	15,481	0.000904	11,079	10	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	599,122	42,284,914		11,272,213	149,968	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part III Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Title XVIII Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,266	0.00	5,752	0		30.00
44.00	04400	SKILLED NURSING FACILITY	7,941	0.00	5,294	0		44.00
200.00		Total (lines 30-199)	16,207		11,046	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Title XVIII Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,728	0.000000	0.000000	15,339	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	308,946	0.000000	0.000000	129,276	54.00
60.00	06000	LABORATORY	0	1,699,690	0.000000	0.000000	750,403	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,296,079	0.000000	0.000000	768,756	65.00
66.00	06600	PHYSICAL THERAPY	0	17,279,666	0.000000	0.000000	3,244,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,502,654	0.000000	0.000000	2,954,780	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,446,704	0.000000	0.000000	1,343,115	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,434	0.000000	0.000000	3,436	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	524	0.000000	0.000000	524	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	966,012	0.000000	0.000000	377,408	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,987,591	0.000000	0.000000	1,649,094	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,723,405	0.000000	0.000000	24,335	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	15,481	0.000000	0.000000	11,079	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	42,284,914			11,272,213	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	602	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	39,665	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	250,470	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	290,737	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII Charges: PPS Reimbursed Services (see inst.)	Title XVIII Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Hospital Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.010537	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.356328	602	0	0	215	54.00
60.00	06000	LABORATORY	0.128346	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.206857	39,665	0	0	8,205	65.00
66.00	06600	PHYSICAL THERAPY	0.220004	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249282	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.249265	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002490	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.694656	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.267323	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227544	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.250357	250,470	0	0	62,707	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.044894	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		290,737	0	0	71,127	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		290,737	0	0	71,127	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037 | Component CCN: 155765 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037 | Component CCN: 155765 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,728	0.000000	0.000000	15,842	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	308,946	0.000000	0.000000	61,679	54.00
60.00	06000	LABORATORY	0	1,699,690	0.000000	0.000000	451,552	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,296,079	0.000000	0.000000	533,371	65.00
66.00	06600	PHYSICAL THERAPY	0	17,279,666	0.000000	0.000000	2,733,152	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,502,654	0.000000	0.000000	2,071,756	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,446,704	0.000000	0.000000	368,842	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,434	0.000000	0.000000	1,830	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	524	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	966,012	0.000000	0.000000	282,748	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,987,591	0.000000	0.000000	1,195,026	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,723,405	0.000000	0.000000	10,852	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	15,481	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	42,284,914			7,726,650	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/29/2013 9:02 pm

Component CCN: 155765

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 9:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.010537	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.356328	0	0	0	0	54.00
60.00	06000	LABORATORY	0.128346	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.206857	0	15,151	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.220004	0	683,296	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249282	0	683,201	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.249265	0	815,182	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002490	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.694656	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.267323	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227544	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.250357	0	386,721	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.044894	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	2,583,551	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	2,583,551	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/29/2013 9:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,134	0	65.00
66.00	06600	PHYSICAL THERAPY	150,328	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,310	0	67.00
68.00	06800	SPEECH PATHOLOGY	203,196	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	96,818	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	623,786	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	623,786	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,266	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,266	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,266	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,752	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,145,141	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,145,141	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	12,089,379	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	12,089,379	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.425592	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,462.54	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,145,141	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	622.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,580,332	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,580,332	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 9:02 pm

	Cost Center Description	Title XVIII Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,570,907	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,151,239	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	180,095	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	149,968	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	330,063	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,821,176	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	258,822	5,145,141	0.050304	0	0	90.00
91.00	Nursing School cost	0	5,145,141	0.000000	0	0	91.00
92.00	Allied health cost	0	5,145,141	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,145,141	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2012 | Worksheet D-1
Component CCN: 155765 | To 12/31/2012 | Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,941	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,941	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,941	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,294	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,208,359	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,208,359	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,591,330	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,591,330	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.238113	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	326.32	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,208,359	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037 | Component CCN: 155765 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,208,359	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	404.02	71.00
72.00	Program routine service cost (line 9 x line 71)	2,138,882	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,138,882	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,138,882	83.00
84.00	Program inpatient ancillary services (see instructions)	1,750,354	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,889,236	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037 | Period: From 01/01/2012 | Worksheet D-1

Component CCN: 155765 | To 12/31/2012 | Date/Time Prepared: 5/29/2013 9:02 pm

		Title XVIII			Skilled Nursing Facility	PPS	
	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 9:02 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,266	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,266	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,266	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	217	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,145,141	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,145,141	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	12,089,379	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	12,089,379	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.425592	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,462.54	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,145,141	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	622.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	135,072	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	135,072	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 9:02 pm

	Cost Center Description	Title XIX Total Inpatient Cost	Title XIX Total Inpatient Days	Title XIX Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	104,290	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	239,362	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/29/2013 9:02 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Title XVIII Hospital PPS Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,345,865		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.010537	15,339	162	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.356328	129,276	46,065	54.00
60.00	06000	LABORATORY	0.128346	750,403	96,311	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.206857	768,756	159,023	65.00
66.00	06600	PHYSICAL THERAPY	0.220004	3,244,668	713,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249282	2,954,780	736,573	67.00
68.00	06800	SPEECH PATHOLOGY	0.249265	1,343,115	334,792	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002490	3,436	9	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.694656	524	1,412	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.267323	377,408	100,890	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227544	1,649,094	375,241	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.250357	24,335	6,092	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.044894	11,079	497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		11,272,213	2,570,907	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		11,272,213		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 153037 | Period: From 01/01/2012 | Worksheet D-3
Component CCN: 155765 | To 12/31/2012 | Date/Time Prepared: 5/29/2013 9:02 pm
Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.010537	15,842	167	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.356328	61,679	21,978	54.00
60.00	06000	LABORATORY	0.128346	451,552	57,955	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.206857	533,371	110,332	65.00
66.00	06600	PHYSICAL THERAPY	0.220004	2,733,152	601,304	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249282	2,071,756	516,451	67.00
68.00	06800	SPEECH PATHOLOGY	0.249265	368,842	91,939	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002490	1,830	5	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.694656	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.267323	282,748	75,585	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227544	1,195,026	271,921	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.250357	10,852	2,717	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.044894	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,726,650	1,750,354	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		7,726,650		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/29/2013 9:02 pm

		Cost Center Description	Title XIX Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		326,271		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.010537	2,970	31	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.356328	1,505	536	54.00
60.00	06000	LABORATORY	0.128346	29,389	3,772	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.206857	24,669	5,103	65.00
66.00	06600	PHYSICAL THERAPY	0.220004	125,178	27,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249282	114,163	28,459	67.00
68.00	06800	SPEECH PATHOLOGY	0.249265	33,934	8,459	68.00
69.00	06900	ELECTROCARDIOLOGY	0.002490	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2.694656	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.267323	26,091	6,975	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227544	94,731	21,555	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.250357	7,428	1,860	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100	EMERGENCY	0.044894	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		460,058	104,290	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		460,058		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E Part B Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	71,127	2.00
3.00	PPS payments	42,196	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	42,196	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	9,094	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	33,102	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	33,102	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	33,102	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	33,102	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	33,102	40.00
41.00	Interim payments	33,102	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2013 9:02 pm

		Title XVIII Inpatient Part A		Hospital Part B	PPS	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,240,253		33,102	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	12/20/2012	14,095		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/20/2012	34,999		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-20,904		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,219,349		33,102	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		15,722		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,235,071		33,102	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2013 9:02 pm

Component CCN: 155765 | Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,342,153		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,342,153		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,342,153		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-3 Part III Date/Time Prepared: 5/29/2013 9:02 pm

Title XVIII | Hospital | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,066,658	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0416	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	243,114	3.00
4.00	Outlier Payments	1,862	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	22.584699	10.00
11.00	Medical Education Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.	0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).	0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)	7,311,634	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)	0	14.00
15.00	Organ acquisition	0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	16.00
17.00	Subtotal (see instructions)	7,311,634	17.00
18.00	Primary payer payments	5,000	18.00
19.00	Subtotal (line 17 less line 18).	7,306,634	19.00
20.00	Deductibles	71,600	20.00
21.00	Subtotal (line 19 minus line 20)	7,235,034	21.00
22.00	Coinsurance	14,739	22.00
23.00	Subtotal (line 21 minus line 22)	7,220,295	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,109	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	14,776	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,901	26.00
27.00	Subtotal (sum of lines 23 and 25)	7,235,071	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	7,235,071	32.00
33.00	Interim payments	7,219,349	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)	15,722	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	1,862	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153037 Component CCN: 155765	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2013 9:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	2,428,453	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,428,453	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	81,787	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	2,346,666	12.00
13.00	Inpatient primary payer payments	4,513	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	2,342,153	15.00
16.00	Interim payments	2,342,153	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-3 Part VII | Date/Time Prepared: 5/29/2013 9:02 pm

		Title XIX Hospital Inpatient 1.00	Cost Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	239,362		1.00
2.00	Medical and other services		623,786	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	239,362	623,786	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	239,362	623,786	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	460,058	2,583,551	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	460,058	2,583,551	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	460,058	2,583,551	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	220,696	1,959,765	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	239,362	623,786	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	239,362	623,786	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	239,362	623,786	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	239,362	623,786	36.00
37.00	ZERO OUT XIX SETTLEMENT	-239,362	-623,786	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G | Date/Time Prepared: 5/29/2013 9:02 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,871,011	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,210,294	0	0	0	4.00
5.00	Other receivable	34,905	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,635,377	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	40,267	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,521,100	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	425,000	0	0	0	12.00
13.00	Land improvements	128,046	0	0	0	13.00
14.00	Accumulated depreciation	-123,852	0	0	0	14.00
15.00	Buildings	14,812,387	0	0	0	15.00
16.00	Accumulated depreciation	-10,554,598	0	0	0	16.00
17.00	Leasehold improvements	382,927	0	0	0	17.00
18.00	Accumulated depreciation	-347,845	0	0	0	18.00
19.00	Fixed equipment	3,352,641	0	0	0	19.00
20.00	Accumulated depreciation	-3,229,131	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,453,400	0	0	0	23.00
24.00	Accumulated depreciation	-1,079,309	0	0	0	24.00
25.00	Minor equipment depreciable	6,585	0	0	0	25.00
26.00	Accumulated depreciation	-6,585	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,219,666	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-19,006	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-19,006	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,721,760	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	250,507	0	0	0	37.00
38.00	Salaries, wages, and fees payable	913,412	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	600,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	133,885	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,897,804	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,350,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,465,584	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	4,815,584	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	6,713,388	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,008,372				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,008,372	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,721,760	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-1 | Date/Time Prepared: 5/29/2013 9:02 pm

		General Fund		Special Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,245,669		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		762,703				2.00
3.00	Total (sum of line 1 and line 2)		5,008,372		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,008,372		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,008,372		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2013 9:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	12,089,379		12,089,379	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,591,330		2,591,330	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,680,709		14,680,709	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,680,709		14,680,709	17.00
18.00	Ancillary services	28,062,132	14,207,299	42,269,431	18.00
19.00	Outpatient services	15,481	0	15,481	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	48,416	0	48,416	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,806,738	14,207,299	57,014,037	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,588,548		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		17,588,548		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 153037 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-3 | Date/Time Prepared: 5/29/2013 9:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	57,014,037	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,897,244	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,116,793	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,588,548	4.00
5.00	Net income from service to patients (line 3 minus line 4)	528,245	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	7,666	6.00
7.00	Income from investments	52,083	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	5	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	3,627	21.00
22.00	Rental of hospital space	24,291	22.00
23.00	Governmental appropriations	0	23.00
24.00	IDENTIFIED ON TRIAL BALANCE	146,786	24.00
25.00	Total other income (sum of lines 6-24)	234,458	25.00
26.00	Total (line 5 plus line 25)	762,703	26.00
27.00	ROUNDING	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	762,703	29.00